

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 82 Primary Registration District No. 3017 Registrar's No. 149 **63-042326** STATE FILE NUMBER

FILED NOV 26 1963

1. PLACE OF DEATH a. COUNTY <u>Cooper</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cooper</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Boonville</u>		c. CITY OR TOWN <u>Boonville</u>	
Length of stay in 1b <u>94 Yrs.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>1026 Sixth St.</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Matilda</u> Middle <u></u> Last <u>Stegner</u>			4. DATE OF DEATH Month <u>November</u> Day <u>15</u> Year <u>1963</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 1, 1869</u>	9. AGE (last birthday) <u>94</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (City and state or country) <u>Boonville, Missouri</u>	
13a. FATHER'S NAME <u>John Adam Stegner</u>		13b. MOTHER'S MAIDEN NAME <u>Margaretta Hoffbacher,</u>		14. NAME OF HUSBAND OR WIFE <u>-----</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Mrs. Margaret Walters, Boonville, Mo.</u>	

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Basal skull fracture</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) <u>Headline</u>		
DUE TO (c) <u>Fall on stairs</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Fell down stairs</u>
---	--	---

20c. TIME OF INJURY <u>5:10</u> Hour <u>11</u> Month <u>11</u> Year <u>63</u> p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. CITY, TOWN, OR LOCATION <u>Boonville</u>	COUNTY <u>Cooper</u>	STATE <u>Mo.</u>
--	---	---	--	-------------------------	---------------------

21. I attended the deceased from <u>7:30</u> to <u>11:18</u> and last saw her alive on <u>11/18/63</u>	22a. SIGNATURE <u>M. L. Decker</u> (Degree or title)	22b. ADDRESS <u>Boonville</u>	22c. DATE SIGNED <u>11/18/63</u>
--	---	----------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Nov. 18, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Walnut Grove Cemetery</u>	23d. LOCATION (City, town, or county) <u>Boonville, Missouri</u>	(State)
--	-----------------------------------	--	---	---------

24. FUNERAL DIRECTOR <u>Goodman & Boller, Boonville, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>11/18/63</u>	26. REGISTRAR'S SIGNATURE <u>Decker</u>
---	---	--

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed William W. Wood

Licensed Embalmer No. 4539

P. O. Address Boonville, Missouri.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.